

# Improving the Qualifications of Experts in Medical Malpractice Cases

by David E. Bernstein<sup>1</sup>

For decades, legal scholars have recognized the problem of physicians testifying beyond their expertise in medical malpractice cases. Sixty years ago, a critic fumed that the same judge who recognizes a general practitioner as competent to testify regarding the conduct of a specialist “will take the train for the Mayo Clinic if he stands in personal need of specialized surgery.”<sup>2</sup> This article explains why courts have historically been liberal about admitting testimony by unqualified or marginally-qualified experts in malpractice cases, discusses recent legislative and judicial innovations that have tightened the standards for admitting medical experts, and proposes a new “reasonable patient” rule that balances the need to ensure that plaintiffs with worthy claims are able to procure expert testimony with assurances that only competent experts will testify.

## *A. Historical Overview*

The main barrier to expert testimony in medical malpractice cases is that plaintiffs are required to show that their experts are “qualified”<sup>3</sup> to testify that defendants breached the relevant

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<sup>2</sup> Hubert W. Smith, *Scientific Proof and Relations of Law and Medicine*, 23 B.U.L. Rev. 143, 147 (1943).

<sup>3</sup> See Fed. R. Evid. 702 and state equivalents.

standard of care in the defendants' specialties.<sup>4</sup> Despite this longstanding rule, for generations medical malpractice plaintiffs have used as expert witnesses physicians with no demonstrated competence regarding the particular issue at hand. Just a decade ago, a federal district court enunciated and applied the standard rule that "[t]he fact that the physician is not a specialist in the field in which he is giving his opinion affects not the admissibility of his opinion but the weight the jury may place on it."<sup>5</sup>

The origins of allowing any medical doctor to testify regarding an alleged breach of the relevant standard of care another physician—even one who practices in a narrow and complex subspecialty—relate to the difficulty plaintiffs in malpractice cases historically faced in finding competent expert witnesses. Until relatively recently, professional solidarity made many physicians reluctant to testify against their colleagues.<sup>6</sup> The once-dominant locality rule compounded this problem. This rule required a medical practitioner's conduct to be assessed based on the standard in the community in which he practices. Applied strictly, the rule required plaintiffs to provide testimony from a physician familiar with the standard of care exercised by

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<sup>4</sup> So far, the *Daubert* reliability test has not been applied in medical malpractice cases, nor has the *Frye* general acceptance test been applied in jurisdictions adhering to that rule. See Daniel W. Shuman, Expertise in Law, Medicine, and Science, 26 J. Health Politics, Pol'y, & L. 267 (2001).

<sup>5</sup> *Smith v. Ortho Pharm. Corp.*, 770 F. Supp. 1561, 1567-68 (N.D. Ga. 1991) (quoting *Payton v. Abbott Labs*, 780 F.2d 147, 155 (1st Cir. 1985)); see also *Letch v. Daniels*, 514 N.E.2d 675, 677 (Mass. 1987) ("A medical expert need not be a specialist in the area concerned nor be practicing in the same field as the defendant."); *Ladner v. Campbell*, 515 So. 2d 882 (Miss. 1987); *Graham C. Lilly*, *An Introduction to the Law of Evidence* 557 (2d ed. 1996) ("A general practitioner of medicine can qualify as an expert on a specialty within medicine even though there are specialists who are more knowledgeable within the restricted field.").

<sup>6</sup> William L. Prosser, *Handbook of the Law of Torts* § 32, at 164 (4th ed. 1971); Richard M. Marshkus, *Conspiracy of Silence*, 14 Clev.-Mar. L. Rev. 520, 523 (1965).

physicians in the defendant's community, which often limited testimony to other physicians practicing in the same community.<sup>7</sup> Not surprisingly, plaintiffs often struggled to locate physicians willing to testify against local colleagues.

Courts compensated for the problems faced by plaintiffs in hiring competent medical experts in malpractice cases by adopting especially liberal qualification rules for such experts.<sup>8</sup> The locality rule was modified to allow non-local experts to testify if they were "conversant with the methods, procedures, and treatments commonly utilized in the locality in which the defendant doctor practices."<sup>9</sup> Many courts went even further, and allowed experts to testify if they were "familiar with acceptable practices in geographic areas sufficiently similar to the defendant's to serve as a fair and adequate guide."<sup>10</sup> At least as significant, courts allowed non-specialists to testify against specialists, and specialists in one field to testify against specialists in another field. This rule substantially increased the pool of potentially experts.

The result of these well-intentioned attempts to aid plaintiffs who otherwise would have gone without medical testimony was that many cases were determined by the "expert" testimony

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<sup>7</sup> Frank M. McClellan, *Medical Malpractice* 173 (1994).

<sup>8</sup> In addition to trying to aid plaintiffs who might otherwise be precluded from presenting their claim, liberal rules for qualifying medical experts were also a reflection of the days when "country doctor" general practitioners still handled almost all medical problems in many parts of the United States. For example, at a time when general practitioners routinely delivered babies, it probably did not seem especially problematic to allow a general practitioner to testify against an obstetrician.

<sup>9</sup> John R. Waltz, *The Rise and Gradual Fall of the Locality Rule in Medical Malpractice Litigation*, 18 *DePaul L. Rev.* 408, 410 (1969).

<sup>10</sup> *Id.*

of unqualified witnesses.<sup>11</sup> The primary issue in a medical malpractice case is breach of the standard of care. Yet physicians were permitted to testify against their colleagues even if an objective observer would doubt that they were sufficiently familiar through both education and experience to both know the standard of care, and to know whether the standard of care was breached by the defendant's acts or omissions.

B. *Further Liberalization of Standards*

Over the last few decades, the demise of the locality rule in favor of a national standard of care<sup>12</sup> increased the ability of plaintiffs to find experts. Meanwhile, professional solidarity in the medical field diminished, and many more physicians became willing to serve as experts adverse to a malpractice defendant. Despite these favorable trends for plaintiffs, some courts continue to adhere to the very liberal rules that arose in an era when expert witnesses were much harder to come by. In some jurisdictions, claimed familiarity with the relevant standard of care still suffices to qualify a witness, even if the witness is not a specialist in the defendant's field and has

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<sup>11</sup> E.g., William A. Wick & Erie A. Kightlinger, *Impartial Medical Testimony Under the Federal Civil Rules: A Tale of Three Doctors*, 24 *Ins. Couns. L.J.* 115, 122 (1967); Francis L. Van Dusen, *The Impartial Medical Expert System: The Judicial Point of View*, 34 *Temp. L.Q.* 386 (1961); David W. Peck, *Impartial Medical Testimony: A Way to Better and Quicker Justice*, 22 *F.R.D.* 21 (1959). For more general discussion of the need for specialized expert testimony, see *supra* § 6.2.

<sup>12</sup> See McClellan, *supra* note 67, at 174; Waltz, *supra* note ?.

never performed the technique in question.<sup>13</sup> These courts allow almost any physician<sup>14</sup>—and in some cases “experts” without medical training<sup>15</sup>—to testify against any other physician in a

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<sup>13</sup> See *Radman v. Harold*, 367 A.2d 472, 475 (Md. 1977) (declining to exclude testimony by internist who had never performed a hysterectomy); *Strach v. St. Johns Hosp. Corp.*, 408 N.W.2d 441, 450-51 (Mich. Ct. App. 1987) (allowing testimony of general surgeon on the issue of malpractice by specialists in thoracic surgery); cf. *Ornoff v. Kuhn and Kogan Chartered*, 549 A.2d 728, 731-32 (D.C. 1988) (expert witness need not be familiar with all the standards of defendant’s specialty).

<sup>14</sup> E.g., *Frost v. Mayo Clinic*, 304 F. Supp. 285, 288 (D. Minn. 1969) (permitting an orthopedic surgeon to testify against a neurologist); *Swope v. Prinz*, 468 S.W.2d 34, 40 (Mo. 1971) (psychiatrist testifies against a surgeon); *Morrison v. Stallworth*, 326 S.E.2d 387, 391 (N.C. Ct. App. 1985) (allowing a surgeon to testify against a gynecologist).

<sup>15</sup> *Zuchowitz v. United States*, 870 F. Supp. 15, 18 (D. Conn. 1994) (pharmacologist may testify regarding alleged malpractice in prescribing medication); *Valiulis v. Scheffels*, 547 N.E.2d 1289, 1296 (Ill. Ct. App. 1989) (clinical psychologist may give an opinion that trauma caused multiple sclerosis); *Wynn v. Mid-Cities Clinic*, 628 S.W.2d 809, 812 (Tex. Ct. App. 1981) (radiological physicist permitted to testify against a radiologist). Most courts, however, are very reluctant to allow non physicians to testify against physicians, even when the non physicians have relevant training. See *Young v. Key Pharm. Inc.*, 770 P.2d 182, 190 (Wash. 1989) (pharmacist may not testify against a physician regarding proper drug therapy for asthma); *Chadwick v. Nielsen*, 763 P.2d 817, 823 (Utah Ct. App. 1988) (excluding testimony of electrical engineer with some relevant knowledge against vascular surgeon); *Harris v. Groth*, 645 P.2d 1104, 1106 (Wash. Ct. App. 1982) (physiologist may not testify against a physician); see also *infra* note ?, and accompanying text (ban on testimony by non physicians against physicians in malpractice cases is the majority rule). That the majority rule makes sense can be seen by considering whether a nonlawyer should be allowed to testify in a legal malpractice case that the defendant lawyer breached the standard of care. For example, an accountant may be competent to testify regarding accounting issues involved in a lawsuit over an allegedly botched will, but will likely be utterly ignorant of the standard of care applicable to attorneys who deal with estate issues, and about certain legal factors that the defendant attorney had to consider. Similarly, a pharmacologist may be competent to testify regarding the side effects of a drug, but will not be competent to testify whether a physician breached the standard of care in prescribing a particular drug to a particular person. This is true both because the pharmacologist will be ignorant of the standard of care applicable to prescribing physicians, and because the pharmacologist will not have sufficient medical knowledge to second-guess the physician’s medical judgment regarding the costs and benefits of a drug to a particular patient. Exceptions may arise where the alleged malpractice was gross and obvious, such as prescribing Accutane, a powerful teratogen used to combat acne, for a pregnant women.

malpractice case, if they can credibly testify that they are familiar with the standard of care.

Meanwhile, the last two decades have seen the rise of medical-legal consulting firms that serve as witness brokers for plaintiffs in need of an expert. These firms have improved the prospects for plaintiffs with legitimate claims, but they also have had troubling effects on the quality of medical expert testimony. In particular, witness brokers' reputations are mostly based on their ability to generate victories and favorable settlements, which tempts them to engage in ethically questionable behavior. One firm, for example, seemed almost to invite plaintiffs' attorneys to proceed with highly dubious claims when it advertised, "[i]f experts have stated that they find no liability in a medical malpractice claim with catastrophic injuries . . . let us analyze the case for you."<sup>16</sup> A critic of witness brokers acidly remarks, "[w]itness brokers imply for quality of science about what escort services imply for quality of marriage."<sup>17</sup>

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<sup>16</sup> Blake Fleetwood, *From the People Who Brought You the Twinkie Defense*, Wash. Monthly, June 1987, at 33. One could generously interpret this ad as stating that if others have failed, maybe this firm can do better. A lawyer might make the same boast -- much of the essence of good lawyering is finding an approach that will work. However, the more natural interpretation of the ad is that regardless of whether an attorney has a medically-valid claim, the agency will find a physician willing to testify on behalf of the attorney's client.

One critic argues:

The law grandly insists that individual witnesses swear to tell the whole truth, but modern rules of evidence in fact encourage dredging of an even more brazen kind. The lawyer dredges not for congenial data points, but for congenial scientists themselves. The upshot of this degenerate process is an expert-witness referral bureau that promises lawyers: "[I]f the first doctor we refer doesn't agree with your legal theory, we will provide you with the name of a second."

Peter Huber, *Junk Science in the Courtroom*, 26 Val. U. L. Rev. 723, 750 (1992).

Of course, attorneys go expert shopping all the time, with or without the aid of brokers. Brokers simply streamline the process. The problem may lie with evidentiary rules that shield attorneys from having to disclose which non testifying experts they contacted, no matter how many of them told the attorney that the case was unsound.

<sup>17</sup> Peter W. Huber, *On Law and Sciosophy*, 24 Val. U.L. Rev. 319, 353 (1990).

The demise of the locality rule has also led to the rise of a class of doctors who make their living primarily by providing consulting services and expert testimony to attorneys throughout the United States.<sup>18</sup> While these doctors retain their licenses, many practice irregularly, if at all.<sup>19</sup> Yet, because of their experience in testifying, that is, performing before a jury, they may be more persuasive to a jury than a leading practitioner in the relevant field.

C. *The Backlash in Favor of Stricter Standards*

Over the last decade or so, there has been a backlash against the extremely liberal rules for qualifying experts in medical malpractice cases, a backlash coinciding with the increased attention given the problem of “junk science” and “quack experts” more generally.<sup>20</sup> Several courts have rejected the view that a purported expert can demonstrate competency simply through familiarity with the relevant standard of care.<sup>21</sup> One court argues that there is a difference between mere knowledge and expertise. To be considered an expert “requires at least some analogous experience in a related field that the expert can draw upon in examining this case.”<sup>22</sup> Courts have ruled that a medical expert needs to have both sufficient knowledge of the

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<sup>18</sup> Cf. *Hall v. Hilbun*, 466 So.2d 856, 875 (Miss. 1985) (criticizing medical experts whose opinions are for sale).

<sup>19</sup> See, e.g., *In re Paoli R.R. Yard PCB Litig.*, 35 F.3d 717, 752 (3d Cir. 1994) (physician had not practiced for years, but had served as an expert in approximately eight hundred cases).

<sup>20</sup> See, e.g., David E. Bernstein, *Frye, Frye, Again: The Past, Present, and Future of the General Acceptance Test*, 41 *Jurimetrics* 385 (2001); David E. Bernstein, *Junk Science in the United States and the Commonwealth*, 21 *Yale J. Int'l L.* 123 (1996).

<sup>21</sup> *Hollingsworth v. United States*, 928 F. Supp. 1023, 1025 (D. Idaho 1996).

<sup>22</sup> *Id.*

standards relevant to the procedure in question, and practical experience actually engaging in the same or a similar procedure.<sup>23</sup>

Some state legislatures have preempted judicial reform by passing statutes regulating medical expert testimony. Several state laws require that physicians who testify in a malpractice case be qualified in the same or a related specialty as the defendant.<sup>24</sup> The general thrust of these statutes—attempting to raise the standards of expert medical testimony—is sound. The statutes

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<sup>23</sup> Williams v Wadsworth, 490 N.W.2d 426, 428-29 (Minn. Ct. App. 1992) Kippers v. Corcoran, 707 So. 2d 463, 465 (La. Ct. App. 1998); *see also* Thomas v. University of Chicago Lying-In Hosp., 583 N.E.2d 73, 77 (Ill. Ct. App. 1991) (excluding testimony of pediatrician against obstetrician because expert had never practiced obstetrics, and “more importantly,” had never treated postpartum bleeding); Crespo v. McCartin, 582 A.2d 1011 (N.J. Super. App. Div. 1990) (excluding testimony by osteopathic physician in case alleging malpractice in diagnosis and treatment of ectopic pregnancy where physician had no training or experience in dealing with such pregnancies); Lawson v. Elkins, 477 S.E.2d 510, 511-12 (Va. 1996) (excluding testimony by neurosurgeon who had never performed or observed specific procedure in question); *cf.* Ancho v. Pentek Corp., 157 F.3d 512, 519 (7th Cir. 1998) (dictum) (heart surgeon is not qualified to opine on spine surgery); *see generally* Poland v. Beard-Poulan, 483 F. Supp. 1256, 1259 (W.D. La. 1980) (“One cannot testify as an expert in regard to a mechanism if he has not had ample opportunity to practically apply his field of expertise to the mechanism at issue.”). An expert can be qualified based on academic study to testify that a mechanism does not work, or was not an appropriate mechanism to use for a particular patient. However, courts should be cautious about qualifying an witness to testify that a physician used a medical device in a way that violated the standard of care if the witness had never used the device in question.

<sup>24</sup> Alabama and Virginia require physicians seeking to testify in malpractice cases practice in the same specialty as the defendant during the year preceding the alleged act of malpractice. Ala. Code § 6-5-548(e) (Supp. 1999); Va. Code Ann. § 8.01-581.20 (1992). In Michigan the proposed expert witness must have specialized at the time of the alleged malpractice in the same specialty as the defendant. If the defendant is board-certified in the specialty, the expert witness must also be board-certified in that specialty. Mich. Comp. Laws Ann. § 600.2169 (1)(a) (West 1999). West Virginia requires that medical expert witnesses be “qualified in the same or substantially similar medical field as the defendant health care provider.” W. Va. Code § 55-7B-7 (1994); *cf.* Pearson v. Parsons, 757 P.2d 197, 199-200 (Idaho 1988) (an expert need not be board-certified). Rhode Island requires expert witnesses in medical malpractice cases to qualify as experts by knowledge, skill, experience, training, or education in the field of the alleged malpractice. R.I. Gen. Laws § 9-19-41 (1997); Marshall v. Med. Assoc. of Rhode Island, 677 A.2d 425, 426 (R.I. 1996).

are problematic, however, in that they do not allow physicians to testify (1) across specialties when testifying not about standards of specialized care, but about general medical practice that a specialist happened to engage in; or (2) when different specialties overlap with regard to a particular treatment.

Florida and Connecticut have passed sounder statutes. These laws impose a presumptive rule that an expert physician must be trained, experienced, and certified in the same specialty as a specialist defendant.<sup>25</sup> However, this presumption can be rebutted by evidence showing that the expert in question possesses sufficient training and knowledge of the relevant standard of care to testify competently against the defendant. A potential problem with these statutes is that they give judges who are not keen on policing expert testimony discretion to admit testimony by physicians who are testifying well outside their sphere of expertise.<sup>26</sup> However, this problem must be weighed against the greater chance that a party—most likely an injured plaintiff—will be unfairly deprived of the ability to present crucial expert medical testimony based on a distinction that is irrelevant in the particular case.

Other states have focused on trying to keep professional experts out of the courtroom. Several states have passed statutes requiring that experts in medical malpractice actions be active

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<sup>25</sup> Conn. Gen. Stat. Ann. § 52-184c(d) (West 1999); Fla. Stat. Ann. § 766.102 (West 2000).

<sup>26</sup> *See generally* Chenowith v. Kemp, 396 So.2d 1122, 1125 (Fla. 1981) (holding that neurologists could testify against a gynecologist); Pool v. Bell, 551 A.2d 1254, 1258 (Conn. 1989) (holding that a neurologist could testify as to the standard of care required of a general surgeon).

practitioners, with practice generally defined to include academic work.<sup>27</sup> Several courts have adopted similar rules by judicial decision. The Delaware Supreme Court excluded testimony by a physician who had not performed the relevant medical procedure in over ten years.<sup>28</sup> A Florida appellate court, meanwhile, excluded testimony by a doctor who had not engaged in the practice of medicine for ten years.<sup>29</sup> The Minnesota Supreme Court found that a physician was not qualified to testify where he had not ordered the relevant procedure in many years, and lacked

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<sup>27</sup> Connecticut requires that an expert testifying in a medical malpractice action have had an active involvement in the practice or teaching of medicine within the five-year period before the incident giving rise to the claim. Conn. Gen. Stat. Ann. § 52-184c (West 1999). In Kansas, medical experts must have spent at least fifty percent of the two-year period prior to the malpractice action in active clinical practice. Kan. Stat. § 60-3412 (1994). Maryland decrees that “[t]he attesting expert may not devote annually more than 20 percent of the expert’s professional activities to activities that directly involve testimony in personal injury claims.” Md. Cts. & Jud. Proc. Code Ann. § 3-2A-04 (a) (4) (1999). In Michigan, the expert must have devoted a majority of his professional time in the year before the incident to either the active clinical practice of the same health profession and specialty as the defendant, or to the instruction of students in an accredited health professional school or accredited residency or clinical research program in the defendant’s health profession and speciality. Mich. Comp. Laws Ann. § 600.2169 (1)(b) (West 1999). Ohio, meanwhile, requires medical expert witnesses to devote seventy-five percent of their professional time to active clinical practice. Ohio Rev. Code Ann. § 2743.43 (Baldwin 1992). In Texas, an expert witness must be practicing at the time of the testimony or have practiced at the time the claim arose. Tex. Rev. Civ. Stat. Ann. art. 4590i, subch. N. § 14.01 (2000). Illinois law requires the trial court to examine whether the witness has devoted a “substantial portion” of his time to the medical practice, teaching, or research related to the issue at hand. 735 Ill. Comp. Stat. Ann. § 5/8-2501 (2000). A later version of this statute, passed as part of a broad “tort reform” measure, required a malpractice expert to devote seventy-five percent of his time to practicing medicine, or engaging in teaching or research relating to the underlying medical problem at issue in the case. The state supreme court declared the entire tort reform statute unconstitutional in *Best v. Taylor Mach. Works*, 689 N.E.2d 1057 (Ill. 1997), thereby reviving the “substantial portion” rule.

<sup>28</sup> *Peters v. Gelb*, 314 A.2d 901, 904 (Del. 1974).

<sup>29</sup> *Winson v. Norman*, 658 So. 2d 625, 626 (Fla. Dist. Ct. App. 1995). The court found that this doctor, who limited his “practice” to litigation consulting, was not a medical expert qualified to execute a verified medical opinion affidavit as required by the relevant statute.

familiarity with current standards.<sup>30</sup>

These rules are potentially effective at restraining hired guns, but may also be overbroad and lead to the exclusion of valuable testimony. As discussed in more detail below, the rules should focus on who a reasonable patient would consult with, not formalistic standards.

D. *Proposal: The Reasonable Patient Standard*

Synthesizing the discussion thus far, the test for the qualification of a medical expert in a malpractice case should be as follows: First, would a well-informed reasonable person who suffered from the medical condition involved in the case seek advice from the proffered expert physician regarding his condition? This criterion would allow testimony in appropriate cases by certain categories of non-practicing physicians, including well-informed disabled or retired physicians. An elderly surgeon with arthritis, or a young former emergency room physician paralyzed in an automobile accident, may be well-qualified to serve as experts as to the best course of treatment for a certain ailment, even though their operating days are behind them.

Second, if the issue before the court involves the alleged mishandling of a particular treatment modality or procedure, is the proffered medical physician sufficiently well-qualified and experienced that the well-informed reasonable patient would be willing to seek treatment from that physician?<sup>31</sup> Only physicians with recent clinical experience with the particular

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<sup>30</sup> Williams v. Wadsworth, 503 N.W.2d 120, 125 (Minn. 1993); *see also* Bellamy v. Payne, 403 S.E.2d 326, 327 (1991) (orthopedic surgeon not qualified to serve as an expert witness in podiatry malpractice case where he kept up with podiatry literature yearly, saw only a small number of patients treated by podiatrists and never attended a course given by podiatrists).

<sup>31</sup> In the case of a recently-disabled physician, the question would be whether a reasonable patient would have sought treatment from the physician before his incapacitating condition struck.

treatment modality or procedure would be permitted to testify, because only they have the appropriate experience to be able to testify as to whether the defendant breached his standard of care.

A potential objection to the reasonable patient standard is that the definition of a “reasonable patient” is bound to be somewhat subjective. This objection is not fatal, however, as Anglo-American courts for generations have been applying a “reasonable man” or “reasonable person” standard in a variety of contexts, without untoward consequences. A reasonable patient, of course, is not necessarily fully informed, nor does he have unlimited financial resources. Courts certainly should not expect plaintiffs to present testimony only from the leading experts in the world. Even patients with life-threatening illnesses do not always seek out such experts, for reasons of convenience, price, timing, and lack of information. But a reasonable patient would only seek advice from a physician with demonstrated professional competence on a relevant medical issue, and only such competent physicians should be allowed to testify if that same medical issue arises in the courtroom.

#### *E. Conclusion*

This article’s proposed reasonable patient standard is novel; it does not appear that any jurisdiction in the United States uses it. Yet, if adopted, the reasonable patient standard would strike a good balance between ensuring that experts in medical malpractice cases are qualified, and ensuring that victims of medical malpractice will be able to hire experts to testify on their behalf.

The reasonable patient standard is both more liberal and sounder than the increasingly popular rule that allows only experts who share the same medical specialty to testify against each

other. In particular, the reasonable patient standard is allows any qualified physician to testify regarding general medical practice.<sup>32</sup> For example, an Illinois court allowed a cardiologist to testify against an orthopedist in a malpractice action alleging that negligent post-operative treatment of the decedent by the orthopedist resulted in cardiac arrest. The court noted that

Decedent died of congestive heart failure, not a broken leg. Defendants' skills, experience or knowledge as orthopedic surgeons are not relevant. . . . We are faced only with the narrow question of the competency of an expert witness to testify to minimum standards of *general* medical practice in the absence of familiarity with the standards of *specialized* orthopedic care. The expert's testimony should not be excluded where the standards to which he proposes to testify are minimum standards applicable to any physician rendering post-operative care to a cardiac patient.<sup>33</sup>

The reasonable patient rule would also allow testimony when different specialties overlap with regard to a particular treatment, as long as a foundation has been laid that members of the proffered expert's specialty would employ the same methods and follow the same procedures as those followed by the defendant's specialty.<sup>34</sup> For example, an internist who had performed over twenty thousand colonoscopies, as well as numerous biopsies, may testify to the standard of care

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<sup>32</sup> See *Gaston v. Hunter* 588 P.2d 326, 347 (Ariz. Ct. App. 1978) (adopting this rule but holding it inapplicable in the particular case); *Gorman v. Shu-Fang Chen, M.D., Ltd.*, 596 N.E.2d 1350 (Ill. Ct. App. 1992); *Burton v. Youngblood*, 711 P.2d 245, 248 (Utah 1985); *Jeffcoat v. Phillips*, 534 S.W.2d 168, 174 (Tex. Ct. App. 1976).

<sup>33</sup> *Petkus v. Girzadas*, 532 N.E.2d 333, 337 (Ill. App. 1988).

<sup>34</sup> See *Burton v. Youngblood*, 711 P.2d 245, 248 (Utah 1985).

expected of gastroenterologists in adjusting anticoagulant levels for patients undergoing colonoscopies.<sup>35</sup>

Meanwhile, the reasonable patient standard avoids the morass of the locality rule. Unlike the locality rule, the reasonable patient standard includes no geographic limitations on experts. Finally, and perhaps most significant, the reasonable patient test is a giant step away from, and a huge improvement to, the let-any-MD testify regime that prevails in some states. In short, the reasonable patient standard ensures that only truly qualified experts testify, without placing onerous and arbitrary burdens on plaintiffs suing for injuries caused by medical malpractice.

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<sup>35</sup> See *Mitchell v. United States*, 141 F.3d 8, 15-16 (1st Cir. 1998).